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Serious Case Reviews into Dementia Care: An Analysis of Context and Content

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Abstract

Adult Serious Case Reviews (SCRs) are commissioned by local Safeguarding Boards to investigate how local professionals and agencies worked together to safeguard a vulnerable adult following an incident of abuse, harm or death if the Board identifies concerns about agencies' actions from which lessons may be learned. This paper presents the results of a study undertaken in 2013 analysing Adult SCRs where the person who was at risk of harm, or had been harmed or died, had a dementia. Of the eighty-four SCRs available, fourteen were identified as involving a person with dementia and in a further seven the victim(s) may have had dementia. Discrete themes are presented: the situation of self- or publicly funded residents; the potential of poor care quality in all settings for people with dementia, and by different staff and family carers; the lack of communication with family members; and poor integration of care for people with dementia. The SCRs provide vivid illustrations of the 'faultlines' that may exist in dementia support systems. In England, Adult SCRs are moving to a statutory basis under the Care Act 2014 and this paper draws attention to their potential as learning materials in dementia care for commissioners, for social workers and for safeguarding practice.

Keywords: Dementia, Serious Case Review, safeguarding, inquiry, elder abuse, social care

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Introduction

There is increasing international interest in adult safeguarding. Among preventive efforts to reduce the risk of elder abuse or neglect in health and care services generally are organisational attempts to learn from errors or harm (Rabøl *et al.*, 2011; Leonard *et al.*, 2004). Within the UK, there is a long tradition of public inquiries which have taken place following tragedies or adverse events, including deaths and harm to vulnerable adults (Stanley and Manthorpe, 2004). One recent and increasingly common form of these at local level is that of a Serious Case Review (SCR), an independent investigation commissioned by the local Adult Safeguarding Board. These generally seek ways to improve professional practice and services, while some make broader observations on policy. Unlike morbidity and mortality conferences in health services (Orlander *et al.*, 2002), SCRs are not confidential in nature and they often involve outside scrutiny of what apparently went wrong. The initial government guidance on multi-agency policies and procedures in adult safeguarding (Department of Health and Home Office, 2000) made no mention of SCRs. However, adult SCR protocols have subsequently been developed by local authorities drawing on guidance from the Association of Directors of Adult Social Services (2006) and most date from this time onwards. In essence, SCRs may be commissioned by a Safeguarding Adults Board following the death or suicide of a vulnerable adult (sometimes referred to as an adult at risk) or their exposure to harm and where there are or subsequently develop substantial concerns about multi-agency or professional (in)action. There has been a steady trickle of SCRs, although in some local authorities none has yet been held.

Curiously, there has been no exploration of SCRs where the vulnerable adult (the victim or subject of the SCR) who died or was harmed had dementia, although aspects of SCRs related to people with learning disability and issues of mental capacity have some overlaps (Manthorpe and Martineau, 2013, 2014). This omission is surprising in light of the rising levels of concern about the quality of care for people with dementia and their vulnerability to abuse (Royal College of Psychiatrists, 2011). SCRs may therefore provide useful observations about current practice and lessons for social work practitioners' and managers' considerations. Decisions in England under the Care Act 2014 to place them onto a statutory basis suggest that they will become a more frequent means of scrutiny of failings in care and treatment or concerns about apparent failings.

Background

The lessons to be learned from SCRs conducted into the death or harm of children in England (Brandon *et al.*, 2010) and from inquiries held when an adult

who had been in receipt of mental health services committed homicide (McGrath and Oyeboode, 2002) are nationally collated and disseminated. In contrast, where the victim concerned was a vulnerable adult, there is local discretion over whether to hold a SCR or inquiry into the circumstances of the harm or death; the threshold for holding a SCR is unclear; there is no duty to co-operate on local agencies, and there is no central oversight of quality. Adult SCR's are not mandatory and vary in their form, availability and content (see Parry, 2014; Manthorpe and Martineau, 2011, 2012). In the UK health services context, the use of Significant Event Analysis (SEA) is widely promoted as a means of learning from issues of concern about patient safety (Bowie *et al.*, 2008, p. 525) but, while these may provide important local learning opportunities, unlike SCR's they generally do not cover other agencies' perspectives and responsibilities; furthermore, they offer little by way of public accountability.

Recent government decisions will change Adult SCR's in England (Department of Health, 2012) by moving them to a statutory basis (to be known as Safeguarding Adult Reviews, or SARs) under the Care Act 2014, with requirements on different agencies to co-operate in the SAR's inquiries or hearings. Government guidance on purpose and methods has recently been published (Department of Health, 2014). The requirement to hold a SAR is likely to impact on practitioners, managers, care providers and funders, since more SARs will likely be undertaken once discretion is withdrawn, with the greater risks of reputational damage if blame is conferred on any agency or professional. For people with dementia and their families, there may be greater access to justice (Manthorpe and Martineau, 2014). Such possibilities suggest the value of considering past SCR's, the aim of this paper, in acknowledgement of their limitations, but also their detailed reflections on aspects of care practice and care systems. In light of the high profile of dementia care in England, illustrated by the Prime Minister's Challenge (Cameron, 2012) and the impact this is having on local services, this subject was chosen as the focus of this analysis of SCR's.

Methods

Obtaining reviews

There is no central repository for Adult SCR's and they are not generally published in full, but as executive summaries. This means that use of a common template for analysis, able to collect details of the case and the whole context, as developed for Children's SCR's (Brandon *et al.*, 2009), would not yield much information, since the material available in executive summaries of Adult SCR's varies in terms of whether it covers details of the incident(s), provides any chronology of events, details communication or contains any expert (second) opinion or evidence. SCR Panel hearings or meetings, unlike public

inquiries, are not held in public and reports of their hearings or the materials considered are not open to scrutiny. Gibbs and Hall (2007) have recently observed the potential of searching the many pages of transcription and written evidence surrounding child-focused reviews but such opportunities are not available to those considering Adult SCRs, nor the method of 'layered reading' (Brandon *et al.*, 2005) entailing reading and re-reading all of the reports associated with a SCR.

Our documentary analysis sought copies of all Adult SCRs undertaken in England that were published before mid-2013 by asking lead managers of local authority adult safeguarding services for copies of such reviews and internet searching using the term Serious Case Review (SCR). Most of those identified on the internet referred to children but we located eighty-four Adult SCRs.

Analysing the reviews

We searched the SCRs for direct or indirect mentions of dementia (this is sometimes referred to as cognitive impairment or Alzheimer's disease and these terms are also used interchangeably in the UK) in the person or people who experienced harm or who had been placed at risk (the term 'victim' is often used as an overarching term in such reports). We then read and re-read the twenty-one SCRs where dementia was indicated and used the categories adopted in our previous documentary analyses of Adult SCRs (Manthorpe and Martineau, 2011, 2012) to classify the SCRs and to identify illustrative examples of the SCRs' observations on the different elements. These elements or categories were developed to cover the essentials of the SCRs in their current formats: their rationale, details of the victims(s), of the alleged abuse or poor practice, the setting and its contexts, the question of blame or culpability of practitioners or other parties, the process of the SCR, and its lessons or recommendations for practitioners and services. Reading and re-reading of the SCR reports or summaries was undertaken in summer 2013 to consider these intra (elements within the SCR report) and inter (comparisons between SCRs) categories. From this, we identified two super-ordinate themes that appear to be distinctive about the twenty-one SCRs relating to people with dementia and which are germane to social work practice, namely recording and continuity of care—these themes are highlighted in the discussion section of this paper.

In some SCRs, the presence of dementia was not explicitly mentioned as affecting the vulnerable adult but our judgement was that its presence was very possible. Our judgement was made on the grounds that these SCRs mentioned the general frailty, including mental frailty, of the individual concerned. In addition, because about 70 per cent of residents of care homes in England have a dementia, whether this is formally confirmed or the home offers services for this client group (Alzheimer's Society, 2012), it is very

possible that the events or concerns about one or a group of residents in a care home might have touched upon the care and treatment of other residents who had a dementia.

Ethical permissions were not needed for this secondary analysis of publicly available data and we note that most of the SCRs used initials to protect the identity of the individual concerned. In some cases, the professionals, social contacts or relatives convicted of offences are named in the SCR or their names are in the public domain, such as in media reports. We have not included these names.

Findings

Table 1 presents some summary details of the main SCRs considered in this paper where the person who was harmed or who died was reported to have had a dementia or a phrase such as Alzheimer's disease, mental frailty or similar was used. Table 2 presents the same details from SCRs where it is possible that the victim or others affected had dementia, in our opinion.

SCR observations

The victim(s)

The SCRs generally addressed the circumstances leading to the decision to hold a SCR by generally outlining a brief chronology of an individual's contact with services or professionals. The presence of dementia is sometimes noted as part of the need for services or reason for referral. In the case of VA1 (Muir, 2011), for example, the initial assessment reported this older person had Alzheimer's disease and a tendency to wander. VA1 was moved to a specialist dementia unit in a care home where concerns accumulated about falls, alleged assaults by other residents, pressure ulcer treatment and care quality, prompting the SCR. In contrast to some SCRs, little information is provided about VA1 as a person, indicating the limits of an executive summary. Even more shadowy are the other residents of the dementia unit. The review noted that, following this case, local health and social services managers (the funders) suspended all their placements to the home and reviewed all residents' care. The outcome of this is not known.

The SCRs reveal differences of approach to those whose placements in care homes were arranged and funded by a local authority (social services) and those who were privately funded, meaning that they arranged and paid for their own care (or this was arranged and paid for by their families). For example, in the case of a care home that was being investigated for reasons of possible neglect, fraud and copious environmental risks, social workers moved all the residents funded by their employing local authority to other

Table 1 Serious Case Reviews where dementia noted ($n = 14$)

Author, date	Age/gender. Mental health diagnosis of subject/victim	Living situation	Relevant incident/s and circumstances	Independent chair
Brake, S. (2010)	80 + /man. Dementia	Residential home	Death—old age. Concern over quality of communication between agencies and assessment, especially around hospital discharge	Designated local authority senior manager
Craddock, M. (2011a)	A number of residents in home for people with dementia	Residential care home	Higher-than-expected death rate—all from natural causes	Yes
Craddock, M. (2011b)	? age/'elderly woman'. Assailant had history of dementia	Residential care home	Death—following attack by elderly male resident	Yes
Flynn, M. (2011)	? age/woman in home where residents with dementia and/or mental disorder over 55	Care home with nursing care	Sexual assaults initially. Other incidents of sexual assault and physical assault by other residents are uncovered	Yes
Halton Safeguarding Adults Board (2011)	Number of residents, all with severe dementia	Care home	Physical and verbal abuse by two staff members, one found guilty of ill treatment and neglect under MCA 2005	Yes
Kent & Medway Safeguarding Vulnerable Adults Committee (2009)	'Older man'. None 'Older woman'. Dementia	Same residential home	Death—natural causes. Adult protection alert raised about quality of care in residential home	Not given
Lawson, J. (2011)	80 + /man. Paranoid schizophrenia; dementia	Own home. Last phase of life in a mental health unit	Death—pneumonia. Concern around differing views of best interests (agencies/ subject)	Yes
Muir, M. (2011)	? age/woman. Alzheimer's disease—had cognitive impairment	Care home with nursing	Death—bronchial pneumonia etc., preceded by alleged assaults	Yes

Nottinghamshire Safeguarding Adults Board, (2011)	50 +/woman. Early-onset dementia; no record of formal test recorded	Care home	Death—natural causes, coroner critical of care provided	Yes
Sexton, M. and Lawson, J. (n.d.)	80 +/woman. Mild to moderate dementia with probable diagnosis of Alzheimer's disease	Own home	Death—house fire. Quality of care in last 3.5 years of life; safeguarding and self-neglect issues	Member of Surrey SAB
Sloper, G. (2010)	Five elderly people (over 65) with dementia/long-standing mental illness	Nursing home	Deaths of five residents—causes consistent with severe neglect	Yes
South Tyneside's Safeguarding Adults Board (2010)	Two women, both 80 + . One with dementia	Own home, prior to move to residential home	Concern around refusal of services; differing views of best interests (subjects/agencies)	Not given
Tennant, L. (2009)	90 +/woman. Dementia	Residential home	Death—hypothermia, following wandering from home, undetected	Yes
White, D. (2011)	Man and woman who died, age and diagnosis unknown; 3 wandering others have dementia	Residential care home for the elderly and/or people with dementia	Concerns about standards of care, including two fatalities resulting from falls	Yes

Table 2 Serious Case Reviews where dementia possible (authors' interpretations) ($n = 7$)

Author, date	Age/gender. Mental health diagnosis of subject/victim	Living situation	Relevant incident/s and circumstances	Independent chair
Curry, J. (2010)	80 + /woman. Long-term mental illness	Own home	Death—house fire caused by own cigarette. Concern over quality of care from agency and family care and self	Yes
Hake, M. (2010)	'Elderly' woman. No diagnosis mentioned, but 'fluctuating levels of cognition'; capacity and consent were subject to practice review	Own home; last phase of life in hospitals	Death—followed a serious fall; criminal investigation dropped; Coroner's report not complete. Concern over care in hospitals	Yes
O'Brien, C. (2010)	'Elderly' man. No capacity issues mentioned	Nursing home	Death—natural causes. Safeguarding Vulnerable Adult procedures invoked; allegations of ill treatment and neglect	Yes
Reader, A. (2010)	70 + /man. Unclear, though report recommends issue of good practice guidance on mental capacity	Own home	Death—no cause of death ascribed. Followed discharge from hospital, died close by. Concern over self-neglect and care by agencies and professionals	Yes
Sheather, M. (2011)	A resident in a care home for 'older people'	Care home	Death—manslaughter and other charges against manager	Yes
Vickers, R. (2010)	80 + /man. No capacity issues mentioned	Care home with nursing	Death—natural causes. Concern over care regime at the care home	Yes
Williams, S. (2010)	90 + /woman. Confusion as to whether she had capacity, but apparently no formal mental capacity assessment	Died at nursing home; but at residential care home up to two days prior to death	Death—natural causes—vascular disease. Pressure sores—possible neglect; decision to move her two days prior to death. Safeguarding issues and concern over agencies' role	Yes

homes but the privately funded residents ‘chose to stay’. This SCR reported the social workers’ ‘numerous attempts to meet and liaise with the families of the 5 privately funded residents, with limited success’ (White, 2011). Other SCRs (see Citarella, 2013; Williams, 2010) have concluded that privately funded residents seemed disadvantaged by their lack of access to social care assessments and reviews, although the authors do not comment on their clinical care or speculate whether a social worker’s involvement might have been helpful.

Details of the alleged abuse or poor practice

SCRs raise concerns about care quality overall in dementia services. For example, they have identified, inter alia, inadequate heating, sub-standard food, fraud, dilapidated conditions in care homes (White, 2011), poor pressure ulcer care (Williams, 2010), physical and sexual abuse (Flynn, 2011) and delays in establishing or reporting that a resident was unaccounted for (Tennant, 2009). More general mention is made of people with dementia not receiving the quality of care that they should have been entitled to expect. The registered manager of one care home was convicted of misappropriation of drugs, manslaughter and perversion of the course of justice (Sheather, 2011) (it is not clear whether this home’s residents had dementia).

In one of the few (three were identified) SCRs conducted into the care and treatment of a person with dementia who was not living in a care home (who died following a fire at home) (Sexton and Lawson, n.d.), a picture is painted of delay in response and action, weak communication and recording, lack of understanding of procedures including adult safeguarding and ineffectual clinical advice.

This theme also arose in the SCR conducted into the care of Mr BB (Lawson, 2011) which noted that his ‘refusal of support/actions was consistently taken at face value’ (p. 15) despite several references to his dementia/cognitive impairment. Similarly, in the case of Mrs Q (a person with dementia) and her blind, disabled sister (South Tyneside’s Safeguarding Adults Board, 2010), questions arose about social workers’ and other professionals’ apparent acceptance of the women’s refusal of care and their poor-quality living conditions. Here, as in several other SCRs, the authors have to surmise what has occurred owing to the limits of record keeping.

The setting and continuity of care

As observed above, one key finding that distinguishes SCRs where the victim is reported as having a dementia from other SCRs is the setting, because most were living in care homes (in England, this term is applied to long-term care facilities with and without on-site nursing). Combined with the possible cases

identified in Table 2, these SCR considered facets of long-term care and the accumulation of different risks—potentially presented by other residents and/or by staff. Some SCR attributed failings to managers and staff; however, several drew attention to fragile communication between the home and the local authority social services department, the local primary care team and with specialist mental health or acute hospital services. For example, the SCR concerning Adult C (Nottinghamshire Safeguarding Adults Board, 2011) was highly critical of arrangements about her move from one care home to another. It highlighted deficiencies in the arrangements for the move, the move itself, the lack of consideration of her best interests, poor transfer of information and care plans, as well as a prescribing error. It viewed communication between visiting clinicians and the care home staff as generally inadequate, with ‘no discernible lines of responsibility or accountability’ for monitoring Adult C’s health (Nottinghamshire Safeguarding Adults Board, 2011, p. 6). Similar pictures of inadequate communication were revealed in the SCR following severe neglect of several residents with dementia in another care home which concluded that ‘Agencies and sections within agencies carried out their separate tasks with little or no reference to each other’ (Sloper, 2010 p. 6).

Several of the SCR scrutinised make reference to the need for greater engagement by health care and social work professionals with care home staff, especially in supporting them when residents’ needs increase, with pressure ulcers and distressing behaviour being illustrations of these highly challenging areas for care home staff. One SCR’s observation that professionals need to cultivate an approach that includes ‘an element of respectful uncertainty in relationships between professional colleagues, within the normal framework of trust and confidence’ (Sheather, 2011) highlights the problem of managing professional relationships. These may be difficult to negotiate when people are paying for their own care or have declined assistance.

The variety of care home provision for people with dementia is illustrated by the SCR that consider safeguarding in settings ranging from large nursing homes (e.g. Craddock, 2011a) that contrast strongly with a family-owned care home for only twelve residents (White, 2011) and suggest that size of setting is no guarantee of safety. In another SCR, the not-for-profit home where Mrs DN spent most of her final months maintained contact with high-status individuals in the locality (Williams, 2010), although concerns over quality of care emerged. The potential for any care home to be a ‘closed’ system emerged in a SCR (Halton Safeguarding Adults Board, 2011) that identified staff friendships, dependencies and cliques as fostering reluctance to raise concerns for fear of reprisals.

Blame and culpability

Few SCR involving people with dementia name those responsible for poor practice. There are exceptions—the care home manager convicted in the

Parkfields case (Sheather, 2011) was named but others convicted of crimes of neglect were not (e.g. Halton Safeguarding Adults Board, 2011). Generally, practitioners are not named but their role is mentioned, as in the instance where a hospital social worker was reported to have arranged a hospital discharge without seeing the patient (Brake, 2010). Few SCR reports discuss professional regulation as a means to promote safeguarding, although occasional references are made to poor recruitment practice (e.g. Flynn, 2011) and inadequate practice supervision (e.g. Halton Safeguarding Adults Board, 2011). There do not appear as yet to have been any SCR reports that have investigated why certain individuals seemed to act abusively or neglect their clients, although the motivations of some family members are touched upon (Lawson, 2011). The culture of some dementia care services was also identified as insufficiently challenged in some SCR reports (Lawson, 2011). Practitioners and managers have been therefore cast as both potential perpetrators of poor practice and its solution; these tensions do not appear to be fully explored.

The review processes

SCR reports' processes were variable but each SCR report itself was generally based on information supplied to the SCR Panel (or individual Chair of the SCR) by different internal management reviews compiled by senior managers of agencies involved in the case or who knew of it. The SCR Chair or Panel generally summarised in the SCR report how it had conducted its task, such as by holding meeting(s) to review the material supplied and to seek further information. The internal review documentation was not always regarded by the authors of the SCR as informative, particularly those that appear to have found it difficult to trace clinical or care records (e.g. Hake, 2010). Some SCR authors commented on the delay in being commissioned to undertake the review; at times, this was attributed to waiting for police or prosecution work to be completed. Some, but not all, made reference to their communications with family members and how this can be managed sensitively (e.g. Muir, 2011).

SCR reports' lessons and recommendations

Flynn *et al.* (2011) noted that SCR recommendations may be specific to agencies or to systems of care. Most SCR reports reviewed covered specific incidents, but also drew attention to poor-quality care systems overall. While many of the deaths or incidents were care-home-located, the reviews generally did not focus on individual blame, but on systems. For example, the review of the care provided to Mrs W and Mr H identified risks of harm, missed opportunities for communication and failure to implement agreed plans, and operational matters were further addressed (Cumbria County Council, n.d.).

While many of these criticisms related to the running of the care home (no ‘management lead, no effective reassessment of risk, no incident recording and no priority or resources were applied either proactively or reactively when Mr H began displaying signs of risky behaviour’), the wider health and care system was castigated and recommendations were made to implement firmer case management and improve communication. Specific recommendations were directed to the care home:

It is recommended that Nursing Home B should review their policy of keeping elderly mentally ill patients who have become physically frail and bed bound in the EMI unit. The mix of elderly physically frail bed bound patients and mobile mental health patients is a significant risk area and consideration should be given to the practical aspects of the living environment with a view to separating the two client groups (Cumbria County Council, n.d.).

Discussion

There are several implications from this present analysis of SCRs for policy makers and practitioners. We discuss these in turn and then acknowledge the limitations of this study. This section concludes by discussing the potential for SCRs to reveal the nature of possible faultlines in dementia care.

Implications

[Sidebotham *et al.* \(2011\)](#) have proposed a unified and detailed database of all Children’s SCRs to enhance the potential of learning from individual reviews. Such ambitions could be applied to Adult SCRs and their successors, the SARs. Professionals and their employers will need to be responsive to this demand for care management records, supervisory records, best interests assessments, social work decisions at all levels and clinical data to be made available to SAR investigators. Those working in safeguarding services to support the SAR process will further need to ensure that data from the CQC, NHS and care provider records, such as SEA and clinical incident reporting, will be included to ensure a full picture of the incident or concern. This present analysis suggests the need for practitioners who have undertaken some of the many contemporary social work roles in dementia care (best interest assessors, safeguarding, assessment and care management) or have been called upon to act as advocates to be aware of the possibility that they will encounter greater scrutiny over cases of suspicious deaths, suggestions of poor practice or non-accidental harm, in conjunction with possible criminal justice involvement and regulatory investigations. A recent high-profile SCR investigating multi-agency responses to allegations of and televised instances of abuse of people with learning disabilities in a private

hospital in England (Winterbourne View) (Flynn, 2012) illustrated that care providers, social workers, including safeguarding practitioners, primary care and secondary health care professionals, potentially face inquiries from the police, regulators, commissioners and professional bodies, as well as sustained media and political interest.

SARs, replacing SCRs, will place new requirements on professionals and managers to co-operate in these processes and it is likely that social workers who are central to local adult safeguarding teams will be leading much of this work. This means that social work practitioners may need to develop or refine their forensic skills of evidence collection, synthesis and analysis, to develop skills such as root cause analysis, to acquire or improve knowledge of what might be evidence of corporate culpability for matters such as negligence, and to be able to support staff, families and those adults at risk or other service users. As noted above, engagement with family members is minimally reported in current Adult SCRs. Social workers may also need to ensure that regular audit, and peer and other supervision are available and could use the evidence of SCRs to confirm the importance of good purposeful records.

Limits of this study

This study is inevitably limited by lack of access to most SCRs and their accompanying documentation and records. This renders direct comparison with SCRs for children and mental health inquiries impossible. There may be other unpublished SCRs and other documents may have been produced which cover similar failings or concerns but which have been labelled otherwise (see, e.g. managerial investigations termed Lessons Learned Reviews, [Doncaster Safeguarding Adults Partnership Board, 2012](#), or the Ombudsman case of a couple with dementia where family members were wrongly excluded from decision making, [Local Government Ombudsman, 2013](#)). Within these limits, the SCRs considered in this paper suggest the value of scrutinising dementia care and practice from a systems perspective yet with the care of an individual at their core. Dementia care arrangements are not generally available in such detail and, while most SCRs cover instances of harm, they present opportunities to report good practice (e.g. [Tennant, 2009](#)).

Faultlines of dementia care

Our super-ordinate themes relate to two main areas of dementia care practice. There is evidence from almost all the SCRs reviewed in this present paper that record-keeping systems and practice may be sub-optimal, in being partial and unsystematic, with minimal standards being interpreted variously. The SCRs in this present analysis appear to have been one of the

few means of integrating all relevant information and professional records related to an individual's dementia care. In doing so, they expose some of the faultlines of dementia care whereby there is risk of poor communication, limited record sharing and little sense of shared care between agencies. Both SCRs and complaints may be of value in training by providing authentic examples of practice and its failings, minor and major, amid the wider contexts of care and support.

Problems with record keeping and general administrative data emerged in many of the SCRs but are not confined to the UK or to dementia care. Flores and Newcomer (2009) investigated administrative data on elderly residential care facilities (RCFEs) in the State of California. They reviewed State RCFE reporting forms for potential data elements, but found little information was computerised. Basic information seemed commonly either not available or out of date.

A second important faultline is discernible in respect of continuity of care. As Moriarty *et al.* (2011) have acknowledged, in England, care homes play an important role in end-of-life care for people with dementia—an estimated location for around 16 – 20 per cent of all deaths (more if the 15 per cent of people who die in hospital having been admitted from a care home are included). However, SCRs provide one important insight into care practice and communication where the potential for people with dementia to be moved to and fro between care homes and hospital and between care homes is revealed. Popham and Orrell (2012) have observed that care homes may be designed and organised according to the priorities of staff and managers rather than the needs of residents and family carers but this may be unduly, if unintentionally, critical of one sector. SCRs are able to capture some of the underlying reasons behind such transitions between settings, teams and areas and the faultlines that may lead to poor practice, abuse and distress if the moves are not well managed or necessary.

Conclusion

Inquiries into failings of care for people with dementia are potentially rich sources of information about service experiences and professional encounters, tragic though many of these cases may be. With the benefit of hindsight, SCRs have the opportunity to consider cases in depth, thus extending the reach of SEA to other agencies and even into the quality of informal or family care. This analysis has reported key points from SCRs where dementia services were engaged which are potentially relevant internationally since there is increasing commitment to improving the quality of life of people with dementia. SCRs' findings resonate with empirical research indicating weak systems of communication across care homes and primary care services (Davies *et al.*, 2011), the potential for people paying for their own dementia care to miss engagement with professional social work

systems (Netten *et al.*, 2001), the dilemmas of working with people who decline services while respecting their decisions or those of their carers (Brodaty *et al.*, 2005) and lack of case management or coordination (Robinson *et al.*, 2010). All these potentially form a major faultline in dementia care. Like any inquiry, SCRs are costly and time-consuming (Manthorpe and Martineau, 2011), thus constructive use needs to be made of them by social work professionals and others. But, in dementia care, where people are not often able to report care deficiencies and abuse or raise complaints, SCRs may offer an opportunity to undertake in-depth analyses of personal, public and professional failings which may help to improve the quality of care and professional practice.

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